DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10182 (10/08)

STATE OF WISCONSIN

BadgerCare+ APPLICATION/REVIEW PACKET

This is an application for BadgerCare Plus and the Family Planning Waiver program. To apply, complete and sign this application, mail or take it to your local county or tribal agency (local agency) or apply online at access.wi.gov. For more information about applying online, see below. To get the address or telephone number of your local agency, call 1-800-362-3002 or go to badgercareplus.org.

If you apply using this application or online, you'll need to provide proof of some of your answers. For more information on what you'll need to provide, see the Verification/Proof Section on page 4.

If you need help filling out this application or want to answer the questions in person or by telephone, contact your local agency.

If you have a disability or need this information interpreted/translated or in a different format, call (608) 266-3356 or 1-888-701-1251 (TTY). These services are free.

Please read pages 1 through 6 for some important things you'll need to know before you apply.

ACCESS - APPLY ONLINE

ACCESS is an online tool that lets you apply for benefits, check the status of your benefits or report changes to your worker. To visit ACCESS, go to access.wi.gov. On ACCESS, you can also apply for FoodShare Wisconsin, which is a program that helps people buy nutritious food. (For more information about FoodShare, go to dhf.wisconsin.gov/em/customerhelp or call 1-800-362-3002.

For questions about BadgerCare Plus or this application, contact your local agency, call **1-800-362-3002** or go to **badgercareplus.org**.

HOW TO USE THIS FORM

1. Read the Important Information, the Rights and Responsibilities sections before you apply.
2. Print clearly, using blue or black ink.
3. Read any instructions, before you answer the question.
4. Answer all the questions. You may have a delay in getting BadgerCare Plus benefits if the application isn't complete.
5. Enter information about all the people living in your home. List all children who live in the home with you at least 40% of the time
6. If more room is needed, use an additional sheet of paper.
7. If you're pregnant, include a signed and dated note from your health care provider. (For more information see the Verification/ Proof Section.)
8. Keep pages 1 – 6, and the BadgerCare Plus Change Report (Attachment 9) for future use.
9. If you want someone to apply for you, complete an Authorization of Representative form. To get this form, go to dhf.wisconsin.gov/em/customerhelp or call 1-800-362-3002.
10. Sign the application. Applications without a signature will be returned.
11. Completed applications must be sent to your local agency. If there isn't an address in the box below, go to badgercareplus.org, or call 1-800-362-3002 (TTY and translation services are available) for the address of your local agency.
12. If you want to apply for FoodShare, complete Attachment 8. (To learn more see page 5.)

Local County or Tribal Agency

IMPORTANT INFORMATION

The following is important information you'll need to know about BadgerCare Plus enrollment.

- It's important to apply as soon as possible because your application date is the date the local agency gets your signed application.
- Pregnant women and people with income below certain limits, who have medical bills in any of the three months before their application date, may be able to get "backdated coverage". If you'd like to request backdated coverage, fill out the Request for Backdated Coverage form (Attachment 5) included in this packet and send it in with your completed application. There is no backdating for the Family Planning Waiver program.
- If you're enrolled in BadgerCare Plus, you'll need to complete a review with your local agency every 12 months to stay enrolled.

ACCESS TO EMPLOYER GROUP HEALTH INSURANCE

If employer-sponsored health insurance is available and the employer pays at least 80% of the total premium, you might not be able to get BadgerCare Plus.

The Department of Health Services will check this information with your employer before you're enrolled.

BADGERCARE PLUS DEDUCTIBLE

If your child is not able to enroll because s/he has access to employer-sponsor health insurance where the employer pays 80% or more of the premium and has family income over 150% of the Federal Poverty Limit, s/he may be still be able to enroll by meeting a deductible.

A deductible is the difference between your family's net income and 150% of the Federal Poverty Limit over a 6 month period. For example, if your monthly income is $100 over the 150% Federal Poverty Limit, you would have to pay a deductible of $600 ($100 X 6 months = $600) to be able to get benefits. (See page 24 for income guidelines.)

OTHER MEDICAL COVERAGE

As a condition of BadgerCare Plus enrollment, you must report to the local agency any third party who may be liable to pay for medical care for yourself and your family. You must cooperate by giving information as requested. This also includes any insurance that may be available through an absent parent or an employer's group health insurance.

PERSONALLY IDENTIFIABLE INFORMATION/SOCIAL SECURITY NUMBER (SSN)

Personally identifiable information and Social Security Numbers are used only for the direct administration of the BadgerCare Plus programs.

If someone in your household is not applying for BadgerCare Plus, you do not need to provide Social Security Number (SSN) or immigration information for that person. Any person who wants BadgerCare Plus, but doesn't provide their SSN or apply for one can't enroll in BadgerCare Plus, pursuant to Wisconsin Statutes § 49.82(2).

If you're applying for BadgerCare Plus, but don't have an SSN due to religious beliefs or because of your immigration status, leave the SSN field on the application blank.

Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration, Department of Revenue, Department of Transportation and the Department of Workforce Development. In addition, the Department of Health Services will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

Your SSN won't be shared with the United States Citizenship and Immigration Services (USCIS).

CHILD SUPPORT COOPERATION

In some situations, you must cooperate with the Child Support Agency to establish paternity, by helping to locate an absent parent, legally naming the absent parent and/or enforcing medical support liability orders if you're requesting BadgerCare Plus. If you don't

cooperate with the Child Support Agency and don't have good cause, your benefits may be terminated if you are an adult and are not pregnant.

RECOVERY OF BADGERCARE PLUS

Wisconsin state law provides for the recovery of certain BadgerCare Plus benefits you get in error. The law also provides for the recovery of certain BadgerCare Plus benefits you get after you turn 55 years old.

RIGHTS

State and Federal laws guarantee rights for anyone applying for or enrolled in BadgerCare Plus, which includes the right to:

- Be treated with respect by state and county employees,
- Confidentiality of all information given to local agencies to determine enrollment, (This doesn't prohibit the use of such information for program administration.)
- Have access to local agency records and files relating to your case, except information obtained by the local agency under a promise of confidentiality,
- The right to remain enrolled in BadgerCare Plus even if temporarily absent from the state, if you remain a Wisconsin resident,
- Be notified if you can be enrolled in BadgerCare Plus within 30 days from the day the local agency receives your application for BadgerCare Plus,
- Be notified in advance of changes in your benefits or enrollment status,
- Ask for reasonable accommodation to participate in the program for a disability-related reason, or the right to request interpreters or translators to participate in the program, and
- Appeal any action taken concerning your BadgerCare Plus application or on-going benefits that you don't agree with by asking for a Fair Hearing.

FAIR HEARING

You may appeal to the Wisconsin Division of Hearings and Appeals or your local agency if:

- Your application for BadgerCare Plus was denied in error,
- Your application was not processed within 30 days from the date the local agency received it,
- You disagree with the local agency's decision to discontinue, terminate, suspend or reduce your benefit, or
- Your request for prior authorization was denied.

You may request a fair hearing by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

Or by calling: Telephone (608) 266-3096

The "Request for Fair Hearing" form can be found at dhs.wisconsin.gov/em/customerhelp.

If you choose to write a letter instead of using the form, you must include:

- Your name,
- Your mailing address,
- A brief description of the problem,
- The name of the local agency,
- Your Social Security Number, and
- Your signature.

Your appeal should include the important facts of the matter and your BadgerCare Plus case number. An appeal must be made no later than 45 days after the date of the action.

You may also contact the local agency where you applied and ask for help filing a Fair Hearing request. Refer to the BadgerCare Plus Enrollment and Benefits handbook (P-10167) to learn more about the fair hearing process. You will get a handbook once a decision has been made on your application or you can find the handbook at dhs.wisconsin.gov/em/customerhelp.

RESPONSIBILITIES

You have the responsibility to provide truthful and complete information on this application, attachments or any other form(s) needed for BadgerCare Plus enrollment.

REPORTING CHANGES

If you're enrolled in BadgerCare Plus, you must report these changes within 10 days:

- You move to a new address or out of state and become a resident of that state (see Note below),
- Anyone moves in or out of your home, or becomes pregnant or gives birth,
- Your living arrangement changes (example: you go into a nursing home or other institution), and
- Your monthly gross income goes over the program limit for your family size.

If you have a change in income and your gross monthly income goes over the program limit for your family size, you must report the change by the 10th day of the next month.

The program income limit for your family size will be in your BadgerCare Plus notices. You should always look at your latest notice for the program income limit for your family size.

BadgerCare Plus Family Planning Waiver

If you're enrolled in the BadgerCare Plus Family Planning Waiver program, you only need to report these changes, within 10 days:

- You move to a new address or out of state, or
- Your living arrangement changes (example: you go into a nursing home or other institution.)

Note: If you move out of state and don't report this move within 10 days, you'll be responsible to repay the BadgerCare Plus program for any payments they made to your HMO. For example, if BadgerCare Plus paid your HMO $475 each month, the amount of overpayment you would have to repay BadgerCare Plus is $475 for each month the HMO was paid, even if you didn't use your *ForwardHealth* card.

How to Report Changes

Report changes online at access.wi.gov, by calling your local agency or you can use the BadgerCare Plus Change Report form (Attachment 9).

VERIFICATION/PROOF

You'll need to provide proof of certain information. Below are examples of proof.

PROOF OF CITIZENSHIP/IDENTITY

People applying for BadgerCare Plus must give proof of their identity, citizenship and/or immigration status. If you have already provided this proof, you don't need to provide it again.

U.S. CITIZENS

If you're a U.S. citizen, examples of what you can use to prove citizenship and identity are in List 1:

List 1

- U.S. Passport,
- Certificate of U.S. Citizenship, or
- Certification of U.S. Naturalization.

If you don't have one of the items in List 1, you must give one item from List 2 and one from List 3.

List 2

- U.S. Birth Certificate,
- U.S. State Department Report of Birth Abroad,
- U.S. Citizen ID card,
- Adoption papers showing U.S. birth,
- Hospital record of U.S. birth,
- U.S. Military Record of Service,
- Life or health insurance record showing U.S. birth, or
- Nursing home admission papers showing U.S. birth.

List 3

- State driver license,
- ID card issued by federal, state or local government,
- U.S. Military Dependent ID card,
- U.S. Military ID card or draft record showing U.S. birth,
- School ID card with photo, or
- For children under age 18, a signed Statement of Identity form. (Attachment 6 of this application packet.)

IMMIGRANTS

If you're an immigrant applying for BadgerCare Plus, you must send a copy of your INS/USCIS documentation showing your immigration status.

Note: Undocumented immigrants can only get coverage for emergency health care services. However, pregnant immigrants can be enrolled in BadgerCare Plus Prenatal Services.

PROOF OF INCOME

Job Income and Wages

Employed adult family members must give proof of their income. This information can be provided on the Employer Verification of Earnings form (EVF-E) or you can use check stubs you have gotten in the last 30 days. If you want to get a form call you local agency. If enrolled, you'll be expected to provide proof of this information at your annual review and when you change jobs.

Self-Employment

You must provide proof of any self-employment income for any family member who is self-employed. You may use copies of your tax forms to provide this proof.

Other Income

You must provide proof of any other income your family gets (example, pensions, Worker's Compensation, disability pay, unemployment from another state, etc.).

OTHER PROOF

Your worker may ask for other proof. Below are some examples of other items for which you may need to provide proof.

- Medical expenses to meet a deductible,
- Documentation for Power of Attorney and Guardianship,
- Pregnancy. (You will need a signed statement from your health care provider that says you are pregnant, what your due date is and if you are having multiple births.)
- Assets. (Only for those applying for the Medicare Premium Assistance program.)

MEDICARE PREMIUM ASSISTANCE)

If you or someone in your home is receiving Medicare Parts A and/or B, s/he may be able to get help paying their Medicare premiums, copayments and deductibles. This is called the Medicare Premium Assistance program. To see if you can enroll in the program, you will need to complete Attachment 7 – Assets, and provide proof of these assets.

FOODSHARE WISCONSIN

FoodShare Wisconsin was created to help stop hunger and to improve nutrition and health. FoodShare helps people with limited money buy the food they need for good health.

To start an application for FoodShare, complete Attachment 8 or go to access.wi.gov.

To learn more about FoodShare Wisconsin, visit dhs.wisconsin.gov/em/customerhelp.

CODE KEYS

The following Marital Status and Race/Ethnic Background codes are to be used in Sections 1 and 3 of the application.

Marital Status Codes

A	=	Annulled
D	=	Divorced
LS	=	Legally Separated
M	=	Married
N	=	Never Married
S	=	Single
W	=	Widowed

Race/Ethnicity information is voluntary and won't be used to make a decision about your benefits.

Race / Ethnic Background Code

A	=	Asian
B	=	Black
H	=	Hispanic Origin
I	=	American Indian/Alaskan Native
P	=	Native Hawaiian/Pacific Islander
S	=	Southeast Asian
W	=	White

CHECK LIST

Please read and check each before you mail your application. This could save time in processing your application.

- ☐ Read the Rights and Responsibilities Sections.
- ☐ Complete all sections of the application that apply to you and your family.
- ☐ Enclose with your application any proof, additional documentation or sheets of paper used to complete the application.
- ☐ Include proof of any income you or your family members have gotten in the last thirty days.
- ☐ If you're a U.S. citizen, provide proof of citizenship and identity. If you have provided this proof already, you won't have to provide it again. Please send copies. Do not send your originals.
- ☐ If you're not a U.S. citizen, provide proof of your immigration status.
- ☐ If you're acting on behalf of an applicant, include the Authorized Representative form or legal documentation that allows you to be the appointed guardian or durable power of attorney for finance.
- ☐ If you're requesting backdated coverage, fill out and enclose the Backdated Coverage Request (Attachment 5).
- ☐ Keep pages 1 through 6 and the BadgerCare Plus Change Report (Attachment 9) for future changes.
- ☐ Sign and date the application form.

If you have these items available on the day you submit this application, include them with your application. You'll be contacted by the local agency and be asked to provide proof of missing, conflicting or vague information, if the information would affect the decision about your BadgerCare Plus enrollment.

If you're having trouble getting what you need to document your citizenship and/or identity, or any other proof needed, contact your local agency for help.

DISCRIMINATION

The Department of Health Services is an equal opportunity employer and service provider. All people applying for or who get benefits are protected against discrimination based on race, color, national origin, disability, age, sex, or religion. State and federal laws require all BadgerCare Plus health care benefits to be provided on a nondiscriminatory basis.

For civil rights questions, call (608) 266-9372 (voice) or 1-888-701-1251 (TTY).

To file a complaint of discrimination, contact either the:

Wisconsin Department of Health Services
Affirmative Action/Civil Rights Compliance Office
1 W. Wilson, Room 555
Madison, WI 53707-7850

Telephone: (608) 266-9372 (voice)
(888) 701-1251 (TTY)
(608) 267-2147 (fax)

OR

U.S. Department of Health and Human Services
Office for Civil Rights – Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

Telephone: (312) 886-5077 (voice) or
(312) 353-5693 (TTY)

BADGERCARE PLUS APPLICATION

Instructions

- Use blue or black ink
- Write all dates in the MM/DD/YY format (example 04/02/58)
- Use an additional sheet of paper if more room is needed.
- Keep pages 1 – 6 and the BadgerCare Plus Change Report (Attachment 9) for future use.
- Race or Ethnic codes are optional. Codes are on page 5.

For County or Tribal Agency Use Only

Case Number _____

Date Received _____

SECTION 1 – APPLICANT INFORMATION

In this section we'll ask about you, the applicant.

Name – Applicant (last, first, MI)		Name at Birth and/or Previous Names	Date of Birth (mm/dd/yy)
Address		City / State	Zip Code
Mailing address, if different from above		City / State	Zip Code
Where were you born? (city/state/country)	Sex ☐ Male ☐ Female	Social Security and/or Alien Registration Number	Race or ethnic code (see page 5)
Are you, the applicant, applying for BadgerCare Plus? ☐ Yes ☐ No		Are you applying for the Family Planning Waiver only? ☐ Yes ☐ No	
Do you need help paying for health care in any of the previous three months, for anyone in your home? ☐ Yes ☐ No If you check yes, complete the Request for Backdated Coverage form (Attachment 5) in this packet.			
Is anyone in your home blind, disabled or unable to work due to illness or injury? ☐ Yes ☐ No			
Do you want your notices printed in ☐ English or ☐ Spanish?		What language is spoken in your home?	
What is your marital status code? (See page 5 for codes.)	Are you a U.S. citizen? ☐ Yes ☐ No	If you are a non-citizen, do you have a sponsor? ☐ Yes ☐ No	
Are you a tribal member? ☐ Yes ☐ No	Are you a child of a tribal member? ☐ Yes ☐ No		

SECTION 2 – CONTACT INFORMATION

Please tell us how we can contact you. Please include the area code for all telephone numbers.

Telephone Number ( )	Type of telephone ☐ Home ☐ Cell ☐ Work	
Other Telephone Number ( )	Who does this number belong to? ☐ Self ☐ Friend ☐ Neighbor ☐ Relative	What is this person's name?
Email Address		
What is the best way and time to contact you during weekdays?		

SECTION 3 – OTHER FAMILY MEMBERS

Tell us about all other people in the home, even if they are not applying. See page 5, for marital status codes and race/ethnicity codes. List all children who live in the home with you at least 40% of the time. Include any child you are responsible for the care of, who is out of the home for 6 months or less. Also include any child that has been removed from your home and placed in foster care or with a relative. Use an additional sheet of paper if more room is needed.

Name – Spouse or Other Adult (last, first, MI)	Name at Birth	Date of Birth (mm/dd/yy)
Applying for BadgerCare Plus ☐ Yes ☐ No	Applying for the Family Planning Waiver Only ☐ Yes ☐ No	
Sex ☐ Male ☐ Female	Where was s/he born? (city/state/country)	Social Security and/or Alien Registration Number
Race or ethnic code (see page 5)	Marital status (see page 5 for codes.)	U.S. Citizen ☐ Yes ☐ No	Relationship to Applicant
Are you a tribal member? ☐ Yes ☐ No	Are you a child of a tribal member? ☐ Yes ☐ No	Sponsor of an immigrant ☐ Yes ☐ No

Name – Child 1 (last, first, MI)	Name at Birth	Date of Birth (mm/dd/yy)
Applying for BadgerCare Plus? ☐ Yes ☐ No	Applying for the Family Planning Waiver Only? ☐ Yes ☐ No	
Sex ☐ Male ☐ Female	Where was s/he born? (city/state/country)	Social Security and/or Alien Registration Number
Race or ethnic code (see page 5)	Marital status code (see page 5)	U.S. Citizen ☐ Yes ☐ No	Relationship to applicant
Tribal member ☐ Yes ☐ No	Child of a tribal member ☐ Yes ☐ No	Is this child in foster care or living with a relative? ☐ Yes ☐ No	*Has paternity been established? ☐ Yes ☐ No

Name – Child 2 (last, first, MI)	Name at Birth	Date of Birth (mm/dd/yy)
Applying for BadgerCare Plus? ☐ Yes ☐ No	Applying for the Family Planning Waiver Only? ☐ Yes ☐ No	
Sex ☐ Male ☐ Female	Where was s/he born? (city/state/country)	Social Security and/or Alien Registration Number
Race or ethnic code (see page 5)	Marital status code (see page 5)	U.S. Citizen ☐ Yes ☐ No	Relationship to applicant
Tribal member ☐ Yes ☐ No	Child of a tribal member ☐ Yes ☐ No	Is this child in foster care or living with a relative? ☐ Yes ☐ No	*Has paternity been established? ☐ Yes ☐ No

Name – Child 3 (last, first, MI)	Name at Birth	Date of Birth (mm/dd/yy)
Applying for BadgerCare Plus? ☐ Yes ☐ No	Applying for the Family Planning Waiver Only? ☐ Yes ☐ No	
Sex ☐ Male ☐ Female	Where was s/he born? (city/state/country)	Social Security and/or Alien Registration Number
Race or ethnic code (see page 5)	Marital status code (see page 5)	U.S. Citizen ☐ Yes ☐ No	Relationship to applicant
Tribal member ☐ Yes ☐ No	Child of a tribal member ☐ Yes ☐ No	Is this child in foster care or living with a relative? ☐ Yes ☐ No	*Has paternity been established? ☐ Yes ☐ No

*Complete only if this person is a child whose parents weren't married at the time of the child's birth. Check "Yes" if paternity has been established by a court action or by a Voluntary Paternity Acknowledgement. Check "No", if it hasn't.

SECTION 4 – OTHER INFORMATION

You must answer yes or no for each question listed below. If you answer yes, you must go to the following Attachments and complete the section indicated.

A. Is any one in your home pregnant? ☐ Yes ☐ No
If yes complete Attachment 1, Pregnant Women.

B. Do any children under age 18, (including unborn children) have a natural or adoptive mother or father who is not living in the home? ☐ Yes ☐ No
If yes complete Attachment 1, Absent Parent. If you are between the ages of 15 and 18 and applying only for the Family Planning Waiver program for yourself, you do not need to complete Attachment 1, Absent Parent.

C. Will anyone in your home get income from a job this month or in the next month? ☐ Yes ☐ No
If yes complete Attachment 2, Employment.

D. Is anyone in your home self-employed? ☐ Yes ☐ No
If yes complete Attachment 3, Self-Employment.

E. Does anyone in your home get income from a source other than a job? ☐ Yes ☐ No
Examples of this income include Social Security, Supplemental Security Income (SSI), maintenance, child support, Worker's Compensation, Unemployment Insurance, disability or sick pay, Veterans Benefits, etc. If yes, complete Attachment 3, Other Income.

F. Does anyone have medical or health insurance now, or in the previous three months? ☐ Yes ☐ No
If yes complete Attachment 4, Health Insurance.

G. If you are applying for the Family Planning Waiver, do you (or if a minor, does your family) have health insurance that pays for your prescription birth control? ☐ Yes ☐ No If yes, you must complete Attachment 4.
If yes, do you have any serious concerns if information about your birth control is sent to your home address? ☐ Yes ☐ No

H. If your child has access to employer-sponsored health insurance where the employer pays at least 80% of the premium, do you want to enroll your child in a BadgerCare Plus Deductible?
☐ Yes ☐ No (For more information on BadgerCare Plus Deductible, see page 2.)
If yes, what is the child's name(s) _____

I. Is anyone in your home court-ordered to pay child support? ☐ Yes ☐ No
If yes complete Attachment 4, Child Support Orders.

J. Was anyone in your home in foster care, court-ordered Kinship Care or a subsidized guardianship on his/her 18th birthday? ☐ Yes ☐ No
If yes, name of person(s) _____

K. Do you or anyone in your home want to apply for FoodShare? ☐ Yes ☐ No
If yes complete Attachment 8, Registration for FoodShare Wisconsin.

SECTION 5 – SIGNATURE

Please read the following statements before signing. If you don't understand any part of this application, contact your local agency.

Under penalties of law and/or perjury, I declare I've read and understand this application and any attachments and to the best of my knowledge, the information I have given is true, correct and complete. I understand the penalties for giving false information or breaking the rules. I understand I'll have to provide proof that what I've said is true. I understand I'll have to repay any benefits paid on my behalf that are issued incorrectly due to my failure to report changes or provide complete and correct information.

I understand my rights as well as my responsibilities and agree to abide by them.

I know that federal rules state any information I've given must be reviewed and verified by state staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get any proof or other information.

I know that BadgerCare Plus doesn't pay medical costs that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the Wisconsin Department of Health Services up to the payment amount that BadgerCare Plus has made for my medical care. This assignment applies to any of my minor children. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

I understand that my signature authorizes the local agency and the Wisconsin Department of Health Services to request any information that's appropriate and necessary for the proper administration of BadgerCare Plus as authorized under Wisconsin law.

SIGNATURE – Applicant or Authorized Representative	Date Signed

Reset Application

ATTACHMENT 1

If more room is needed for any section, use an extra sheet of paper.

PREGNANT WOMEN

You'll need to provide proof from a health care provider of the pregnancy.

Name of pregnant woman	Due date	If multiple births, number of babies expected.
Name of pregnant woman	Due date	If multiple births, number of babies expected.

ABSENT PARENT

Is there a reason you don't want to provide information for an absent parent? ☐ Yes ☐ No
If yes, leave this section blank. You'll be contacted by your local county or tribal agency for more information. If no, complete the section below.

Name of absent parent (last, first, MI)	Name of child or write "unborn" if pregnant (last, first, MI)
Name of absent parent (last, first, MI)	Name of child or write "unborn" if pregnant (last, first, MI)
Name of absent parent (last, first, MI)	Name of child or write "unborn" if pregnant (last, first, MI)

Reset Attachment 1

EMPLOYMENT

ATTACHMENT 2

Complete this section for anyone else in your home who'll get income or in-kind income from a job this month or in the next month. By in-kind income we mean a job that pays only in goods or services instead of money. For example, someone who gets free housing in exchange for work. Use an additional sheet of paper if more room is needed.

Name of employed person (last, first, MI)	Employer name, address and telephone number	
Date employment started (mm/dd/yy)		
Is this person on strike? ☐ Yes ☐ No	How many hours does this person work each week?	
Is this person paid by the hour or salary? ☐ Hourly ☐ Salary	If hourly, much each hour? $	If salary, how much each pay period? $
Does this person get cash and/or tips? ☐ Yes ☐ No If yes, how much per pay period? $_____	Does this person get bonuses and/or commissions? ☐ Yes ☐ No If yes, how much each pay period? $_____	
How often are you paid? ☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month ☐ Other If other, explain _____		
Job Type ☐ Permanent ☐ Temporary	Job Title ☐ Manager ☐ Staff	
If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck $
Is this person a migrant worker? ☐ Yes ☐ No		

Name of employed person (last, first, MI)	Employer name, address and telephone number	
Date employment started (mm/dd/yy)		
Is this person on strike? ☐ Yes ☐ No	How many hours does this person work each week?	
Is this person paid by the hour or salary? ☐ Hourly ☐ Salary	If hourly, much each hour? $	If salary, how much each pay period? $
Does this person get cash and/or tips? ☐ Yes ☐ No If yes, how much per pay period? $_____	Does this person get bonuses and/or commissions? ☐ Yes ☐ No If yes, how much each pay period? $_____	
How often are you paid? ☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month ☐ Other If other, explain _____		
Job Type ☐ Permanent ☐ Temporary	Job Title ☐ Manager ☐ Staff	
If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck $
Is this person a migrant worker? ☐ Yes ☐ No		

EMPLOYMENT (CONTINUED)

Complete this section for anyone else in your home who'll get income or in-kind income from a job this month or in the next month. By in-kind income we mean a job that pays only in goods or services instead of money. For example, someone who gets free housing in exchange for work. Use an additional sheet of paper if more room is needed.

Name of employed person (last, first, MI)	Employer name, address and telephone number	
Date employment started (mm/dd/yy)		
Is this person on strike? ☐ Yes ☐ No	How many hours does this person work each week?	
Is this person paid by the hour or salary? ☐ Hourly ☐ Salary	If hourly, much each hour? $	If salary, how much each pay period? $
Does this person get cash and/or tips? ☐ Yes ☐ No If yes, how much per pay period? $_____	Does this person get bonuses and/or commissions? ☐ Yes ☐ No If yes, how much each pay period? $_____	
How often are you paid? ☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month ☐ Other If other, explain _____		
Job Type ☐ Permanent ☐ Temporary	Job Title ☐ Manager ☐ Staff	
If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck $
Is this person a migrant worker? ☐ Yes ☐ No		

Name of employed person (last, first, MI)	Employer name, address and telephone number	
Date employment started (mm/dd/yy)		
Is this person on strike? ☐ Yes ☐ No	How many hours does this person work each week?	
Is this person paid by the hour or salary? ☐ Hourly ☐ Salary	If hourly, much each hour? $	If salary, how much each pay period? $
Does this person get cash and/or tips? ☐ Yes ☐ No If yes, how much per pay period? $_____	Does this person get bonuses and/or commissions? ☐ Yes ☐ No If yes, how much each pay period? $_____	
How often are you paid? ☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month ☐ Other If other, explain _____		
Job Type ☐ Permanent ☐ Temporary	Job Title ☐ Manager ☐ Staff	
If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck $
Is this person a migrant worker? ☐ Yes ☐ No		

Reset Attachment 2

ATTACHMENT 3

SELF-EMPLOYMENT

List the amounts you reported to the IRS on your tax form. If you didn't file taxes last year, leave the net annual income and depreciation boxes empty. Your local agency will contact you for more information.

Name of self-employed person	Name and address of business
Net annual income $	
Depreciation amount claimed $	Type of business
Do you expect any changes in your net income this year? ☐ Yes ☐ No	

Name of self-employed person	Name and address of business
Net annual income $	
Depreciation amount claimed $	Type of business
Do you expect any changes in your net income this year? ☐ Yes ☐ No	

OTHER INCOME

Please list below all other income you and/or your family members get each month.

Type of income	Name of person who gets this income (first, last, MI)	Gross monthly amount
		$
		$
		$
		$
		$
		$
		$

Reset Attachment 3

ATTACHMENT 4

HEALTH INSURANCE

Complete the following if anyone has medical or health insurance now, or in the previous three months.	
Policyholder's name	Name and address of insurance company
Policy number	
Begin date	
Who is or was covered under this policy? Family Member's Name(s):	
Has this coverage ended in the last three months? ☐ Yes ☐ No If yes, what is the date the coverage ended? _____ Why did the coverage end?	
Is/was this insurance provided by an employer? ☐ Yes ☐ No If yes, what is the employer's name?	
Does this insurance cover services from a doctor? ☐ Yes ☐ No	
Does anyone in your household have Medicare? ☐ Yes ☐ No	What is that person's name?
Does this person want help paying their Medicare Part A and/or Part B premiums and/or deductibles? ☐ Yes ☐ No If yes, complete Attachment 7 – Assets.	

CHILD SUPPORT ORDERS

Complete this section for the person(s) in your household who is court-ordered to pay child support. If you get child support, list the amount you get in Attachment 3, under Other Income.	
Who is court-ordered to pay child support?	Monthly court-ordered amount $
Who is court-ordered to pay child support?	Monthly court-ordered amount $

Reset Attachment 4

ATTACHMENT 5

REQUEST FOR BACKDATED COVERAGE

If you are requesting backdated coverage, complete, sign and return this attachment with your application. Coverage can only be backdated for three months. Please keep in mind, requesting backdated coverage doesn't guarantee you'll be enrolled for the months requested.

If the information on the application form is different for any of the three months before your application month, list the differences below for each month that you're requesting backdated coverage. Your application month is the month your application is received by the local agency. Differences may include: address, people in your household, income, health insurance. You must provide proof of income for any of the three months you are requesting backdated coverage.

What is the date you want coverage to begin?_____

1. For what month are you requesting backdated coverage? _____

Is any information included in your application different in this month from the application month? ☐ Yes ☐ No
If "Yes", describe the changes.

If your income was different, what was your total gross family income for this month? $_____

2. For what month are you requesting backdated coverage? _____

Is any information included in your application different in this month from the application month? ☐ Yes ☐ No
If "Yes", describe the changes.

If your income was different, what was your total gross family income for this month? $_____

3. For what month are you requesting backdated coverage? _____

Is any information included in your application different in this month from the application month? ☐ Yes ☐ No
If "Yes", describe the changes.

If your income was different, what was your total gross family income for this month? $_____

SIGNATURE – Applicant / Authorized Representative	Date Signed

Reset Attachment 5

ATTACHMENT 6

STATEMENT OF IDENTITY FOR CHILDREN UNDER 18 YEARS OF AGE

This Statement may be used only to meet the new Medicaid/BadgerCare Plus/Family Planning Waiver proof of **identity** rule for children under 18 years of age. This statement may not be used to meet the Medicaid, BadgerCare Plus or Family Planning Waiver proof of citizenship rule.

Instructions: In the space provided below, list all the children under age 18 in your household for whom you are a parent, guardian or caretaker relative. For each child you list, include the child's date of birth and place of birth (city, state and country). **Complete, sign and return this statement to your local county or tribal agency.**

Child's Full Name (First, MI, Last)	Date of Birth	Place of Birth (City, State, Country)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Personally identifiable information will be used only for the direct administration of the BadgerCare Plus and Medicaid programs.

By signing this statement, I certify, under penalty of perjury and false swearing, that the information I have given is correct and complete to the best of my knowledge. I understand that the local agency may contact other persons or organizations, to confirm the accuracy of my statement.

SIGNATURE _____ Date Signed _____
(Parent, Guardian or Caretaker Relative)

Print Name _____ Case Number _____
(Parent, Guardian or Caretaker Relative)

Reset Attachment 6

ATTACHMENT 7

ASSETS

If you want to apply for the Medicare Premium Assistance or Buy-In program, you must list all your family's assets. Include assets owned jointly with any other person. Do not include the value of personal household belongings (televisions, furniture, appliances). Do not list motor vehicle information in this section. Assets include items such as cash, checking or savings accounts, certificates of deposit, trust funds, stocks, bonds, retirement accounts, interest in annuities, U.S. savings bonds, property agreements, contracts for deeds, timeshares, rental property, life estates, livestock, tools, farm machinery, Keogh plans or other tax shelters, personal property being held for investment purposes, etc.

NOTE: You will be required to provide proof of all your assets. Examples of proof include a copy of your bank statement showing the value of your bank account on the date the application is completed, or something that shows the face value and cash value of your life insurance policy. Use an additional sheet of paper if more room is needed.

Type of Asset (See Above)	Name of Owner(s)	Current Dollar Amount	Bank / Financial Institution Name and Account Number

BURIAL ASSETS

List all burial assets.

Type of Burial Asset		Name of Owner(s)	Value
Burial Insurance	☐ Yes ☐ No		$
Irrevocable Burial Trust	☐ Yes ☐ No		$
Other	☐ Yes ☐ No		$

VEHICLE INFORMATION

List all motor vehicles. Include vehicles owned jointly with another person.

Vehicle 1

Type of vehicle	Year	Make	Model
Amount owed on vehicle $		Fair Market Value* $	

Vehicle 2

Type of vehicle	Year	Make	Model
Amount owed on vehicle $		Fair Market Value* $	

*By fair market value, we mean the amount that you would get if you sold it on the open market.

LIFE INSURANCE

Please tell us about any life insurance you and/or your family has.

Do you or any family member have any life insurance policies? ☐ Yes ☐ No If yes, complete the section below.

Name of Owner(s)	Cash Value $	Face Value $
	$	$

Reset Attachment 7

APP

ATTACHMENT 8

REGISTRATION FOR FOODSHARE WISCONSIN

Complete this form if you want to request FoodShare benefits. You may have another adult complete the application process for you. If your FoodShare benefits stopped within the last 30 days you may complete this form or contact your worker to find out if you can provide information to reopen your FoodShare without completing this form.

You can start the application process for FoodShare online at access.wi.gov or you can complete this page and return it to your local agency. You can also apply online at access.wi.gov, by mail, in person or by telephone. To complete the application for FoodShare, you must have an interview. The interview will be done by telephone, unless you prefer to go to the agency.

You will be asked to provide proof of certain information such as identity, address and income. If you are enrolled in FoodShare, benefits will begin from the date a completed registration form (online or paper) is received by your local agency.

Name – Applicant (Last, First, MI)			
Social Security Number (Optional)	Date of Birth (Optional)	Telephone Number (Optional)	
Address – Street	City	State	Zip Code
Signature (Applicant or Authorized Representative)		Date Signed	

Is there anyone living in your home who is not listed on the BadgerCare Plus application? ☐ Yes ☐ No

Your FoodShare application will be processed as soon as possible, but no later than 30 days from the date your registration form is received by the FoodShare office.

If you need help right away or have an emergency, you may be able to get FoodShare benefits within 7 days of providing your registration form, if your household:

- Has $100 or less available in cash or in the bank and
- Expects to receive less than $150 of income this month; **or**
- Has rent/mortgage or utility costs that are more than your total gross monthly income, available cash or bank accounts for this month; **or**
- Includes a migrant or seasonal farm worker whose income has stopped.

Answer the following questions to be considered for faster service.

Total gross income expected by your household this month (before taxes or other deductions)	$_____
Total available assets (examples-cash, money in checking/savings accounts, CDs, stocks, IRAs, etc)	$_____
Total rent or mortgage this month	$_____
Total utilities this month (examples- gas, electric, water, sewer, trash removal)	$_____
Is anyone in your household a migrant or seasonal farm worker whose income has recently stopped and does not expect to receive more than $25 in income, in the next 10 days?	☐ Yes ☐ No

Tear Off and Submit This Page to Your Local FoodShare Office

Keep the attached pages. If you do not understand any part of this form, ask you local agency to explain it.

Reset Attachment 8

Important Information - FoodShare

FoodShare is an entitlement. You do not have to apply for W-2 or other programs to be able to get FoodShare benefits. FoodShare benefits are available to help meet nutritional needs in low income households. A household is usually made up of people who live together and share food. The amount of FoodShare benefits a household gets is based on the household's size and income. FoodShare benefits are issued on a Wisconsin QUEST card which is used like a debit card at grocery stores that take part in FoodShare.

NON-DISCRIMINATION

In accordance with Federal law and the U.S. Department of Agriculture policy, this institution (local county or tribal agency) is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs or disability.

To file a complaint of discrimination write to the USDA or the Department of Heath Services:

USDA
Director, Office of Civil Rights
Room 326-W, Whitten Building
1400 Independence Avenue, S.W.,
Washington D.C. 20250-9410

Telephone: (800) 795-3272 (voice) or
(202) 720-6382 (TTY)

Department of Health Services (DHS)
Affirmative Action/Civil Rights Compliance Office
1 W. Wilson, Room 555
Madison, WI 53707-7850

Telephone: (608) 266-9372 (Voice) or
1-888-701-1251 (TTY)
Fax: (608) 267-2147

USDA is an equal opportunity provider and employer.

FAIR HEARING

You have the right to a fair hearing if you do not agree with any action taken regarding your application or your ongoing benefits. You may request a fair hearing by writing or calling:

Department of Administration
Division of Hearing and Appeals
P.O. Box 7875
Madison, WI 53707-7875
(608) 266-3096

The Request for a Fair Hearing form may be downloaded at dhs.wisconsin.gov/em/customerhelp. You may also contact your local county or tribal office to ask for a Fair Hearing verbally or in writing.

USE OF SOCIAL SECURITY NUMBERS/PERSONALLY IDENTIFIABLE INFORMATION

Personally identifiable information, including Social Security Numbers (SSN) will be used only for the direct administration of FoodShare Wisconsin. Providing or applying for an SSN is voluntary; however anyone who does not provide their SSN or apply for one, will not be able to get FoodShare benefits. Anyone in the household who is not applying for FoodShare does not need to provide an SSN. Your SSN permits a computer check of your information from government agencies, such as the Internal Revenue Service (IRS), Social Security Administration, Department of Workforce Development or School Lunch Program. SSNs are also used to check identity and to verify income from sources such as employers.

AUTHORIZED REPRESENTATIVE

You have the right to have another person apply for FoodShare benefits for you. This person will act as an "authorized representative". If you want to have an authorized representative, complete the Authorization of Representative form (F-10126). To get this form go to dhs.wisconsin.gov/em/customerhelp or ask the local agency. If an authorized representative provides wrong information which is used to determine your FoodShare benefits, you will be responsible for any mistakes.

IMMIGRATION STATUS

To be able to get FoodShare, you must be a United States citizen or have a qualifying immigration status with the United States Citizenship and Immigration Services (USCIS). Immigration status of all people applying for FoodShare will be verified with USCIS and may affect FoodShare enrollment and benefit amount. Immigration status will NOT be verified with USCIS for any person who is not applying for FoodShare or who indicate they do not have qualifying immigration status with the USCIS. However, income from those individuals may affect FoodShare enrollment or benefit amount.

COLLECTION OF INFORMATION

The collection of information on the application, including the Social Security Number of each household member applying, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036 to determine if your household is able to take part in FoodShare Wisconsin. Information will be verified through computer matching programs and will also be used to monitor compliance with FoodShare program rules and program management.

COMPUTER CHECK

Information on your application will be subject to verification through the state income and eligibility verification system. If you work, job income and wages you report will be checked by computer against wages your employer reports to the Department of Workforce Development. The IRS, Social Security Administration and Unemployment Insurance Division are also contacted about income and assets you may have. Information from these agencies may affect your household's enrollment and/or benefit amount.

If any information you give is found to be incorrect, you may be denied FoodShare benefits and/or be subject to criminal prosecution for knowingly providing false information. You must repay any benefits you get, if you gave false information. If a FoodShare claim is made against your household, information on the application, including all Social Security Numbers, may be referred to federal and state agencies, as well as private collection agencies for claims collection action.

FOODSHARE PENALTY WARNING

Any member of your household who intentionally breaks any of the following rules can be barred from FoodShare for 12 months after the first violation, 24 months after the second violation or for the first violation involving a controlled substance, and permanently for the third violation.

- Giving false information or hiding information to get or continue to get FoodShare benefits,
- Trading or selling FoodShare benefits,
- Using FoodShare benefits to buy nonfood items, like alcohol or tobacco,
- Using another person's FoodShare benefits, identification cards or other documentation.

Depending on the value of the misused benefits, you can also be fined up to $250,000, imprisoned up to 20 years or both. A court can also bar you from FoodShare Wisconsin for an additional 18 months. You will be permanently disqualified if you are convicted of trafficking FoodShare benefits of $500 or more. You will not be able to take part in FoodShare Wisconsin for 10 years if you are found to have made a fraudulent statement or representation with respect to identity and residence to receive multiple benefits at the same time. Fleeing felons and probation/parole violators are not able to take part in FoodShare Wisconsin. You may also be subject to further prosecution under other applicable federal laws.

If you trade (buy or sell) FoodShare benefits for a controlled substance/illegal drugs, you will be barred from the FoodShare program for a period of 2 years for the first finding and permanently for the second finding. If you trade (buy or sell) firearms, ammunition or explosives, you will be barred from FoodShare Wisconsin permanently.

CHG

ATTACHMENT 9

BADGERCARE PLUS CHANGE REPORT

You must report, within 10 days if:

- You move to a new address or out of state,
- Anyone moves in or out of your home, someone becomes pregnant or gives birth, or
- Your living arrangement changes (example: you go into a nursing home or other institution).

You must report by the 10th of the following month if you have a change in income in which your gross monthly income goes over the program limit. If you're enrolled in BadgerCare Plus, you'll get a notice which will have the program limit for your family size listed. You should always look at your latest notice.

BadgerCare Plus Family Planning Waiver

If you're enrolled in BadgerCare Plus Family Planning Waiver, you only need to report these changes within 10 days:

- You move to a new address or out of state, or
- Your living arrangement changes (example: you go into a nursing home or other institution.)

You can report these changes using this form, by calling the county or tribal agency or online at access.wi.gov. If you choose to use this form, once you've completed and signed the form, return it to your local agency. See page 23, for the address and telephone number of the local agency, call 1-800-362-3002 or go to badgercareplus.org.

If this report doesn't provide enough room to describe a change, attach a sheet of paper with the additional information.

Your Name	Case Number/Social Security Number	Worker Name

CHANGE IN ADDRESS

Use this section to report a new address.

New address	City	State	Zip Code
New telephone number		Date of change	

CHANGE IN HOUSEHOLD

Use this section to report if anyone moves in or out of your household, if anyone gets married, becomes pregnant or gives birth (include information about the person who gave birth and the newborn.)

Name(s) (last, first, MI)		Date of change
Social Security Number	Relationship to you	Date of birth
Describe the change		

Do not send this form with your application. Keep this form for future use.

CHG

CHANGE IN INCOME

Use this section to report a change in gross income amount, a new source of income, changes in employment status (part-time to full-time or full-time to part-time, loss of employment), changes in salary or rate of pay, changes in the amount of Social Security, Veterans benefits, Unemployment Insurance, Worker's Compensation, or any other change in the amount of money your household receives.

Name (last, first, MI)		Date income changed
Source of income	Monthly amount	How often paid

New Job

If this is a new job change, what is the employer's name, address and telephone number?	
How many hours per week do you work?	Amount paid per hour?

Loss of Job

Name (last, first, MI)		Date ended
Name of Employer	Date of last paycheck	Amount of last paycheck? $

OTHER CHANGES

Use this space for any other changes you want to report.

SIGNATURE

I understand that there are penalties for hiding information or giving false information. I also understand that I may have to pay back any benefits I get because I don't fully report changes in my circumstances. I agree to provide proof of any changes, if asked to do so. My answers on this form are correct and complete to the best of my knowledge.	
SIGNATURE – Applicant/Authorized Representative	Date Signed

Local County or Tribal Agency Address and Telephone Number

Reset Attachment 9

BadgerCare Plus and FoodShare Wisconsin enrollment are based on federal guidelines (Federal Poverty Level – FPL). The chart below lists the FPLs for BadgerCare Plus and FoodShare. These numbers change by a small amount each year. Currently amounts are published at dhs.wisconsin.gov/em/CustomerHelp.

BadgerCare Plus (Effective March 1, 2008 through February 28, 2009)

Family Size	150% FPL	200% FPL	300% FPL
1	$1,300.00	$1,733.33	$2,600.00
2	$1,750.00	$2,333.33	$3,500.00
3	$2,200.00	$2,933.33	$4,400.00
4	$2,650.00	$3,533.33	$5,300.00
5	$3,100.00	$4,133.33	$6,200.00
6	$3,550.00	$4,733.33	$7,100.00
7	$4,000.00	$5,333.33	$8,000.00
8	$4,450.00	$5,933.33	$8,900.00
For each additional person add:			
	$ 450.00	$ 600.00	$ 900.00

FoodShare Wisconsin (Effective October 1, 2008 through September, 30, 2009)

Family Size	100% FPL	200% FPL
1	$ 867	$1,734
2	$1,167	$2,334
3	$1,467	$2,934
4	$1,767	$3,534
5	$2,067	$4,134
For each additional person add:		
	$300	$600